PLUMBERS & STEAMFITTERS LOCAL 486 MEDICAL FUNDS
6650 BELAIR ROAD, SUITE ONE
BALTIMORE, MARYLAND 21206

SUBROGATION AGREEMENT

I, Roger Books have submitted a claim(s) to the Plumbers & Steamfitters Local 486 Medical Fund (hereinafter called the "Claim"). I may have legal rights on account of acts or omissions of a third party (or parties) which caused or contributed to the illness or injury which resulted in the Claim. I also may be entitled to benefits or payments on account of such injury or illness, irrespective of a third party's act or omission. In consideration of the fund's payment of benefits with respect to the Claim, I agree to reimburse (or direct others to reimburse) the Fund for the entire amount it paid with respect to the Claim out of any money I receive or am entitled to receive, from a third party, its insurer, or any other person or entity (public or private) which is attributable or related in any manner to such illness or injury.

I further agree that I will notify the Fund of any attorney, insurance company representative, or other person whom I have contacted or will contact to assist me in seeking money on account of the claim and I will direct such person to release all information to and fully cooperate with the Fund. I agree that this Agreement irrevocably directs such attorney, insurance company representative, or other person to pay the Fund the entire amount owed to the Fund under this agreement out of any settlement, judgement, or other recovery.

I represent that I have not accepted any money with respect to the illness or injury which resulted in the Claim. I agree that until the Fund is reimbursed in full for the benefits it paid which are attributable to the Claim, I will not accept any money with respect to such illness or injury without the Fund's written consent.

I also agree that the Fund has the right to pursue its reimbursement claim directly against the third party and upon the Fund's request, I agree to assign to the Fund any right of recovery or cause of action in tort, or any other claim or cause of action which I have or may have, to the extent of the amount of benefits paid by the Fund with respect to the Claim. I agree to cooperate fully with and assist the Fund in any action it may take pursuant to this Agreement.

Roger Books
Roger Books *Signature of Participant*

220-76-6233
Your Social Security Number

Date

PLEASE PRINT

a. Name of your attorney Donald J. Arnold

b Your attorney's address/telephone # 403 Fulford Ave., Bel Air, MD 21014
(410) 879-4847

c. Name(s) of injured person(s) Rita L. Books, wife

Date of Accident 5/20/98

GIVE DETAILS OF ACCIDENT ON BACK OF THIS FORM

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INFORMATION REGARDING THE CLAIM FOR ACCIDENT/ILLNESS

Please print or type - if you need additional space use back or attach separate piece of paper.

For each other Party involved in the accident or injury:

a. Their name(s): Driver - Bryan Timothy Smoot

b. Their Address: 19 E. Heath St.
Baltimore, MD 21230

c. Name of their Insurance Company: Liberty Mutual Ins. Co.

d. Policy Number: Claim # AB550 050 486 01

e. Address & Telephone # of Insurance Company: P.O. Box 29601
Charlotte, N.C., 28229 (800) 532-7706

f. Name, Address and Telephone # of their attorney: None as of present

2 a Name of your attorney: Donald J. Arnold

b. Your attorney's address & telephone #: 403 Fulford Ave., Bel Air, MD 21014
(410) 879-4847

c. Name of your insurance company State Farm Ins. Co.

d. Address of your insurance company & telephone #: P.O. Box 757, Bel Air,MD 2101
(410) 638-8553

Details of accident or illness:

a. Date of Accident/Illness: May 20, 1998

b. Full and Complete details of accident or illness:
See attached police report

4. Name of any person(s) injured for whom benefits are sought from the Fund:

a. [] Participant [X] Dependent(s) Involved in Accident/Illness:
Rita L. Books

b. Participant's Name: Roger Books

c. Participant's Social Security #: 220-76-6283